LOUISIANA DEPARTMENT OF HEALTH
Medicaid

The Louisiana Health Insurance Premium Payment Program
LaHIPP

APPLICATION FOR THE LOUISIANA HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

Medicaid Assistance with Paying Insurance Premiums

- Fill out this application to see if you qualify for the Louisiana Health Insurance Premium Payment (LaHIPP) Program. Applicants must be working or have someone in their family who is working and eligible for health insurance offered from that job. LaHIPP can help pay some or all of the health insurance premiums for an employee and his or her family if they meet those requirements and a family member also has Medicaid.
- If you need extra space, use a separate sheet of paper.
- If you have any questions, call **1-855-618-5488** Monday–Friday between 8:00 AM–4:30 PM to speak with a LaHIPP representative, or visit us online at our website **http://ldh.la.gov/lahipp**.
- Complete and mail this application to **LaHIPP, 7389 Florida Blvd. Suite 400, Baton Rouge, LA 70806** or fax it to **1-855-618-5486**. You can also e-mail a copy of this application to **La.HIPP@la.gov**.

What is your preferred language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____

► *Please **PRINT** clearly in black ink.*

1 — Personal Information

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

2 — Contact Information

Mailing Address			Home Address *(if different)*		
P.O. box or street address		Apt/Lot #	Street address		Apt/Lot #
City	State	Zip	City	State	Zip
E-mail address *(required for payment reimbursement)*			Home parish *(where you live)*		

Cell phone	Home phone	Other phone

3 — Members of your Household

*List **ALL** people living in your home. If no one lives with you, leave this section blank and skip to section 4.*

	Person 1	Person 2	Person 3
Name			
Relationship to you			
Social Security number			
Date of birth			
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Is this person enrolled in a group health plan?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, is this health plan court ordered?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is this person pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, what is the name of the birthing center? *(if applicable)*			

4 — Health Insurance *(other than Medicaid)*

Does anyone in your household have health insurance? ☐ Yes ☐ No *(If **NO**, skip to section 5)*

Is this insurance court ordered? ☐ Yes ☐ No

Name of policyholder	Policyholder phone number

Mailing address of policyholder *(if they do not live in your home)*

Insurance company name

Insurance company address

Insurance company phone	Policy number	Group number

Policy premium *(if known)* $	How often is the premium paid/deducted? ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Quarterly ☐ Other:_____

Please provide a front and back copy of the health insurance card for this policy for verification

5 — Employment

Do you or anyone in your household work? ☐ Yes ☐ No *(If **NO**, skip to section 6)*

	Job 1	Job 2	Job 3
Worker's name			
Worker's phone number			
Is this person self-employed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Employer name			
Employer address			
Employer phone number			
Name of Human Resources contact at this employer			
Is health insurance available from this job?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Insurance company name			
Policy Number			
Group Number			

6 — Former Employment

Have you or anyone in your household lost a job in the last 30 days? ☐ Yes ☐ No *(If **NO**, skip to section 7)*

	Job 1	Job 2	Job 3
Worker's name			
Worker's phone number			
Former employer name			
Former employer address			
Former employer phone no.			

7 — Payment Registration

*To receive LaHIPP payments, you **MUST** register with the Division of Administration's (DOA) LaGov system. To register with the LaGov system, download and complete the **W-9 Form** from the website below.*
http://ldh.la.gov/lahipp

Do you or anyone in your household have a bank account that can be used for electronic deposits? ☐ Yes ☐ No

*If you wish to receive payments through electronic funds transfers (EFTs) instead of paper checks, visit the website below and download the **EFT Enrollment Form** from that page. Have your bank or financial institution assist you with completing this form.*
http://ldh.la.gov/lahipp

YOUR RIGHTS AND RESPONSIBILITIES

When you apply for assistance with Louisiana's Health Insurance Premium Payment (LaHIPP) Program, you agree to the following:

- I will cooperate in giving LaHIPP information about health insurance from my job and I will enroll in this insurance. I will also enroll dependents who get Medicaid if LaHIPP decides it is cost-effective to help pay for the insurance.
- I will continue to keep group health insurance from my job as long as I get LaHIPP premium payments.
- If I decide that the requirements to enroll or stay enrolled in group health insurance cause me a hardship, I will contact the LaHIPP program and ask for a review of my situation.
- I agree that LaHIPP can contact any person, medical provider, insurance company, employer, or other organization/agency to get information about health insurance, medical treatment and employment for me and/or my dependents.
- I agree to tell LaHIPP within 10 days about:
  - Changes in what the health insurance covers
  - Changes in the cost of the insurance
  - When a pregnancy ends
  - When Medicare becomes available
  - Changes in the insurance company
  - If a job ends
  - If anyone moves out of state
- I agree that if I get money from LaHIPP for my insurance that I should not have received, I will have to pay the money back to the Louisiana Department of Health.
- I agree that LaHIPP can use the Division of Administration's (DOA) LaGov electronic system to make payments to me for my health insurance premiums and that LaHIPP can give DOA and my bank any information that they need in order to make those payments. I agree to register with the LaGov system or to allow LaHIPP to act on my behalf to register me, and I consent to all of the applicable terms and conditions for the use of the LaGov Supplier Self Registration Portal. If I wish to receive payments through electronic funds transfers (EFTs) instead of paper checks, I agree to submit an EFT enrollment form that has been filled out by me and my bank.

Your Rights

- LDH cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to the Louisiana Department of Health, Human Resources at P. O. Box 4818, Baton Rouge, LA 70821-4818.

Read and sign below

By signing this application I am giving my permission to the State of Louisiana and its agents to verify the information given on this application. Under penalty of perjury, I certify that all information is true and correct to the best of my knowledge. I have read or someone has read to me the "Rights and Responsibilities" section of the application.

Sign here:	Date:

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Employer Health Insurance Information Form

- This form **MUST** be completed by the employer providing health insurance to the LaHIPP applicant, in order to make a final determination of eligibility for premium reimbursement of health insurance. Although some information may not relate to the applicant and/or they may not currently have health insurance, this information is still needed.
- If you need extra space, use a separate sheet of paper.
- If you have any questions, call **1-855-618-5488** Monday–Friday between 8:00 AM–4:30 PM to speak with a LaHIPP representative, or visit us online at our website **http://ldh.la.gov/lahipp**.
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What is your preferred language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____

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1 — Employer Information	
Employer name	
Employer address	
Employer phone number	Does this employer offer health insurance to its employees? ☐ Yes ☐ No *(If **NO**, skip to section 6)*

2 — Employer Insurance Information	
Insurance carrier name	
Insurance carrier phone number	Are multiple plans offered by this insurance carrier? ☐ Yes ☐ No *(Please submit a summary of benefits for all plans with this form)*
Is there an Open/Annual Enrollment Period? ☐ Yes ☐ No	If **NO**, when would changes to insurance go into effect?
If **YES**, what are the dates for this period? Begin date: End date:	When would changes to insurance go into effect for this period?

3 — Insurance Coverage Information

What coverage is provided by your insurance carrier? *(Check all that apply)*

☐ Major Medical ☐ Dental ☐ Inpatient Hospital ☐ Outpatient Hospital
☐ Cancer Only ☐ Pharmacy ☐ PPO ☐ HMO
☐ Skilled Nursing ☐ Medicare Supplement ☐ Emergency Transportation ☐ Home Health
☐ Vision ☐ High Deductible — Amount: _____ ☐ Other: _____

Tell us your employee's share of monthly premiums. If any standard tiers are not applicable, please indicate with N/A)

Standard Tiers	Monthly premium share	Other Tiers *(if applicable)*	Monthly premium share
Employee Only	$		$
Employee and Children	$		$
Employee and Spouse	$		$
Family	$		$

How frequent are premium deductions?

☐ Weekly (**48** times a year) ☐ Weekly (**52** times a year) ☐ Biweekly (**24** times a year) ☐ Biweekly (**26** times a year)
☐ Monthly ☐ Semi-Monthly ☐ Annually ☐ Other: _____

4 — Employee Information (ACTIVE)

Is the LaHIPP applicant a **current** employee or someone who receives coverage from a **current** employee's insurance plan?
☐ Yes ☐ No *(if **NO**, skip to section 5)*

Provide the following information for the active employee.

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

Insurance policy number	Insurance group number

Is the first month's premium deducted from this employee's paycheck before coverage becomes effective? ☐ Yes ☐ No

Can changes be made to this coverage by the employee at times other than open/annual enrollment? ☐ Yes ☐ No

Provide the following information for all dependants of the active employee who are enrolled or have been enrolled in their health insurance plan. Include information for the active employee.

Name	Social Security Number	Date of Birth	Insurance Effective Date	Insurance End Date

5 — Employee Information (TERMINATED)

Is the LaHIPP applicant a **terminated** employee or someone who receives coverage from a **terminated** employee's insurance plan? ☐ Yes ☐ No *(if **NO**, skip to section 6)*

Provide the following information for the terminated employee.

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

When did employment end?	Did this employee elect to enroll in COBRA coverage? ☐ Yes ☐ No

If **YES**, what was the name of their COBRA contact?

COBRA phone number	COBRA fax number *(if applicable)*

Provide the following information for all dependants of the terminated employee who are enrolled or have been enrolled in their health insurance plan. Include information for the terminated employee.

Name	Social Security Number	Date of Birth	Insurance Effective Date	Insurance End Date

6 — Form Filer Information and Signature

Name of employer representative completing form

Employer mailing address

Employer phone number	Employer fax number *(if applicable)*

Sign here:	Date:

Thank you for your time in providing Medicaid and LaHIPP the opportunity to assist your employee!